

DALLAS (A)

THE TREATMENT
—OF—
INGUINAL HERNIA.

BY
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Although numerous articles are constantly appearing on the subject, the treatment of Hernia has not kept pace with the recent advances in other branches of surgery; and, to-day, there is no subject of like importance in which there is so little interest taken and consequent want of knowledge displayed by the body of the profession. *It is still too much the custom among physicians to consign their ruptured patients to the tender mercies of the druggist or truss-maker, who is totally ignorant of anatomy, and whose only object is to effect a sale.* To prove the correctness of these statements it is only necessary to examine the methods of treatment in use at the present time, and as these methods naturally divide themselves into the palliative or mechanical, and the radical or surgical, we will first take up the palliative.

PALLIATIVE TREATMENT.

In the palliative treatment of hernia, trusses of various shapes have been used in all ages to prevent the protrusion of the gut, and, if possible, to effect a cure, and the appliances used to-day are virtually the same as those used a century ago. They are all constructed on the same general principle—a powerful spring, a large pad, and a



strong strap, and keep up the rupture by the same means—brute force. The application of the retaining force in these trusses is wrong. When applied laterally, as by the usual method, it is used at a disadvantage, and greater pressure has to be employed, *while the pad is bound to slip down until it rests on the pubic bone.* When applied from below upward, the greatest pressure is at the lowest point, *and the injury to the spermatic cord and vessels is intensified.* The shape of the ordinary pad, too, is an anomaly, and its usual method of application is unscientific. Its convex surface, driven into the parts by the powerful spring, and kept in constant motion during walking, etc., *bore's its way into the hernial opening and actually enlarges it.* Another equally serious objection to these trusses, and one which has been entirely too much overlooked, is the fact that, in every case, their point of greatest pressure is at and below the external ring, *where there is only integument to prevent the pinching of the spermatic cord and vessels between the pad and the pubic bone.* We freely admit the evils due to pressure upon the uterine nerves, and we should no longer ignore the equally serious and positive injury due to pressure upon the spermatic vessels, and which gives rise to well-marked symptoms. Recently flat pads and elastic belts have been introduced, *but the flat pads only increase the pressure at their lower edges, and elastic belts intensify the injury by the constancy of their pressure.*

Forced by these considerations, I have devised for my own patients a truss that appears to meet all requirements. It is light and cool. It rests

upon the pelvis—an immovable support. There is no constricting band around the hips to cause atrophy of the muscles and interfere with every movement. There is, consequently, no excoriation to heal up, as the pad is not disturbed. The belt comes down along the flank, breaking the lateral recoil that causes the protrusion, and so acting as an auxiliary to the pad. The pad itself is small, somewhat diamond-shaped, with its surface slightly concave, the better to adapt itself to the convex abdominal walls. The pressure, *applied from above downward*, is *slight and wholly over the internal ring*. *Running from the centre of the face of the pad to its lower edge is a gradually-deepening groove that prevents compression of the vas deferens and spermatic vessels and nerves.*

RADICAL TREATMENT.

But there are cases of hernia in which palliative treatment is not sufficient, and in which more radical measures have to be resorted to. Sometimes the hernia is so large or so painful that the patient is disabled; while, in other cases, an operation is desired by the patient or undertaken at the suggestion of the surgeon. For these cases many operations have been devised by different operators, but we are virtually reduced to the consideration of what may be called the American operation. Introduced by a prominent surgeon, and adopted by his followers, it soon became the rage, and, for the time being, has displaced other and better methods. Naturally, we look for points of excellence in it beyond those of the others, but we fail to find them. In performing it, all the safeguards that Nature throws around

the canal are cut away and packed together in a heterogeneous mass, leaving only a thin layer of fascia and the peritoneum. On this fascia grows granulations which, it is claimed, form an unyielding cicatrix, strong enough to resist protrusion. Now, in other parts of the body we are taught that cicatricial tissue rapidly disappears under pressure and motion, and we direct our treatment accordingly. (We see a proof of this, also, in the frequency of hernia after laparotomy; and, should a recent suggestion of Tait's be carried out, the number will be largely increased.) And yet we are asked to believe that this particular cicatrix, subjected to incessant pressure and motion from its very inception, will remain firm and unyielding. Is it any wonder, then, that we see so many cases in which the cicatrix has become so thin that the movements of the intestines can be seen through it; with a protrusion so large that no ordinary truss can hold it; and with a sensitiveness so great that no pressure can be tolerated? The victim of this operation always reminds one of the man in the parable, in which we are told that the "last condition of that man was worse than the first." Fortunately, there are better operations than this, but whatever method be adopted, the surgeon should be able to guarantee his patient that, whether successful or not, *his condition will not be made worse than it was*. The operation that I believe will give the best results with the fewest drawbacks is as follows: Make the first incision along the pubic bone, commencing at the symphysis, and extending outward from three to four

inches ; then carry a second incision upward at almost right angles to the first, and parallel with the inguinal canal. Dissect up this triangular flap of skin freely, and turn it back, and the whole field of operation is exposed. (Occasionally it may be necessary to make a third incision down over the scrotum.) Dissect down to the sac in the usual way, loosen any adhesions, push the sac well up inside the internal ring, and fasten it to the external portion of the internal ring with strong catgut sutures, bringing the sutures out above and tying them there. Then bring the pillars of the ring together with several sutures, check all oozing, turn down the skin flap, and thoroughly coaptate the edges, and you have virtually a subcutaneous wound. The adhesion of the skin over and around the canal gives a firmness to the parts that they so much need ; the sac acts as a pad to divert the protruding gut ; the approximation of the pillars narrows the canal to its normal dimensions ; the resiliency of the now closely adherent, unbroken skin helps in a measure to prevent further protrusion, while there is no external cicatrix to be irritated by the truss that it is always advisable to put on after the operation.

Midway between the palliative and radical treatment of hernia comes the old Heaton method of injecting into the hernial sac an irritant solution to excite adhesive inflammation. With ordinary precautions, and in properly selected cases, this is perfectly harmless and has given fairly satisfactory results. If the irritant be used in powder form, the results are even more satisfactory.

TREATMENT OF STRANGULATED HERNIA.

When speaking of the indications for radical treatment, I said nothing of strangulated hernia, a class of cases that figure largely in hospital reports, and give a high death rate. All authorities claim that in a considerable proportion of these cases reduction is impossible and operative interference compulsory. This I no longer believe. In all the years of my practice, part of the time surgeon to works employing thousands of mechanics, amongst whom such cases are frequent, I have never had to operate for strangulated hernia, nor had I ever any trouble in reduction since adopting my present method. When called to a case of this kind, I at once give an injection of morphine and atropine, to which, latterly, I add a little cocaine. I repeat this injection every ten or fifteen minutes until the patient is quite comfortable. Meantime, I *make him drink*, every five minutes, from a half to a cupful of a mixture consisting of: Strong black coffee Oj, fluid extract of ergot 3 ij-3 iv, and, occasionally, when the pulse is weak, gr. $\frac{1}{80}$ – $\frac{1}{60}$ strychniæ. Generally, within a half-hour the rupture has become flaccid, and gentle taxis reduces it. I use no anesthetics or hot baths, or external applications, and have reduced cases when other physicians have failed.

Of 545 recorded cases of strangulated hernia operated on, 260 died.

By using the above simple method of treatment, the necessity for operating would have been obviated and the death rate would have been *nil*.

AT HOME,
9 TO 12.

65 WEST 36TH STREET.

New York, Jan. 5, 1892.

Dear Doctor:

I take the liberty to notify you that I now devote my attention entirely to the treatment of Mernia. For the last fifteen years I have made a special study of the subject, and I can, therefore, give these cases intelligent attention. Should you kindly favor me with any patients, they will receive my best care.

Yours respectfully,

ALEXANDER DALLAS, M. D.

